



Functional Nutrition Patient Information

Please keep the first two pages for your records. They DO NOT need to be returned.

FUNCTIONAL MEDICINE CONSULTATION FEES

Initial consultation with Dr. Ballard: \$200

Follow up appointments are time dependent as follows:

- 20 Minutes - \$55
- 30 Minutes - \$70
- 40 Minutes - \$85
- 50 Minutes - \$100

PAYMENT OPTIONS

Cash, checks, or credit cards (MasterCard, Visa, Discover) are all accepted methods of payment for services. When you schedule the initial visit, we will collect a prepay consult fee of \$200 for that visit. We request a credit card on file, no charges will be applied to your credit card unless you miss or cancel an appointment without proper notice. On the day of your scheduled appointment, all charges for consultations, laboratory testing and nutritional supplements will be itemized, and payment is due on day of service.

Follow-up phone, or in person consultations will be billed to your credit card on file unless you provide other payment information and instructions prior to your appointment. If additional lab tests are required and our office sends test kits, the appropriate fees will be charged to your account. **The credit card on file will also be used for supplements mailed unless otherwise specified.**

INSURANCE

Medical insurance is not accepted, and our office cannot assist you with claim resolution. Functional Medicine is considered preventative care and therefor not a covered service for most insurance providers. Charges are typically HSA eligible.

MEDICAL RECORDS

Medical records can only be released with your authorization. Please fill out a Records Release form for each provider you have seen in the last 3 **years** and make sure that we have received them **at least 5 DAYS** prior to your initial appointment.

Your medical records should be faxed to our office:

Fax #: (866) 849-1536



Functional Nutrition Patient Information

OFFICE HOURS

Our office hours are Monday, Wednesday, and Friday:
8:30 am – 12:00 pm & 2:00 pm - 5:30 pm CST.

CONTACT INFORMATION

- **Phone messages left will be responded to within 24 hours (during business hours)**
- To reach the office, please call or text (217) 347-5010
- If you call or text after hours, the office staff will respond to your request on the next business day
- When leaving a message, please be brief and include the following information:
 - ✓ Full name
 - ✓ Reason for call
 - ✓ Preferred contact method

Email contact information:

Tammie (appointment scheduling and supplements)

info@ballardfamilychiro.com

LATE ARRIVALS, CANCELLATIONS AND RESCHEDULES

We are committed to being on time with patients' appointments in order to prevent clients from waiting. If you arrive late to the office for your consult, your appointment will end at the scheduled time, and you will be charged for the length of the originally scheduled visit.

Due to the dedicated nature of the appointment time, we require notice of cancellation or reschedule of your visit **by 12:00 pm on our office working day before your appointment**. If you do not notify our office, you will be charged a **\$50 fee**. Please remember our office hours are Monday, Wednesday, and Friday.

RETURNS

Due to the individualized nature of products ordered and lack of quality control once supplements leave the office, we are unable to accept returns of supplements.

ORDERING SUPPLEMENTS

Supplement orders are placed every Monday and typically arrive Wednesday. Ask about our Patient Direct Program to have your supplements drop shipped to you directly.



Functional Nutrition Health History Questionnaire *TO BE FILLED OUT BY PATIENT*

*Please fill out the Health History Questionnaire as accurately as you can.
The more information you can provide, the better.*

*Be sure to return this portion to our office
no later than 5 days prior to your initial consultation.*

We would like to take the time to thank you for choosing our office to assist you with your journey to optimal health. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the doctor during your consultation.

Name: _____ Date: _____

Email: _____ Phone: _____

Address: _____ City: _____

State: _____ Zip: _____

Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Marital Status:

Single Married Divorced Widowed Long Term Partnership

Occupation: _____ Hours Per Week: _____ Retired

Genetic Background:

African American Hispanic Mediterranean Asian Native American

Caucasian Northern European Other (Please describe): _____

CURRENT HEALTH STATUS/CONCERNS

Please provide us with current and ongoing problems.

| Problem | Date of Onset | Severity/Frequency | Treatment | Success |
|---------------------------|-----------------|---------------------|----------------------------|-------------------------|
| <i>Example: Headaches</i> | <i>May 2006</i> | <i>2 times/week</i> | <i>Acupuncture/Aspirin</i> | <i>Mild improvement</i> |
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What diagnosis or explanation(s), if any, have been given to you for these concerns?

When was the last time you felt well? _____

What seems to trigger your symptoms? _____

What seems to worsen your symptoms? _____

What seems to make you feel better? _____

What physician or other health care provider (including alternative or complimentary practitioners) have you seen for these conditions?

What treatments/tests were recommended?

Do you have copies of your testing? Y / N

If yes, please include when sending this questionnaire to the office.

If no, please fill out a records release for each provider you saw and include them when sending this questionnaire to the office.

PAST MEDICAL AND SURGICAL HISTORY

If you have experienced reoccurrence of an illness, please indicate when, or how often under comments. Please feel free to use additional paper for any other information if needed.

| Illness | When/Onset | Comments |
|--|------------|----------|
| Anemia | | |
| Arthritis | | |
| Asthma | | |
| Bronchitis | | |
| Cancer (Specify type) | | |
| Chicken Pox | | |
| Chronic Fatigue Syndrome | | |
| Chron's Disease or Ulcerative Colitis | | |
| Diabetes (Specify type) | | |
| Emphysema | | |
| Epilepsy, convulsions, or seizures | | |
| Gallstones | | |
| German Measles | | |
| Gout | | |
| Heart Attack, Angina | | |
| Heart Failure | | |
| Hepatitis | | |
| Herpes Lesions/Shingles | | |
| High blood fats (cholesterol, triglycerides) | | |
| High blood pressure (hypertension) | | |
| Irritable bowel (or chronic diarrhea) | | |
| Kidney stones | | |
| Measles | | |
| Mononucleosis or EBV | | |
| Mumps | | |
| Pneumonia | | |
| Rheumatic Fever | | |
| Sinusitis | | |
| Sleep Apnea | | |
| Thyroid disease, Whooping Cough | | |

PAST MEDICAL AND SURGICAL HISTORY

If you have experienced reoccurrence of an illness, please indicate when, or how often under comments. Please feel free to use additional paper any other information if needed.

| Injuries | When | Comments |
|--------------------------------------|------|----------|
| Back injury | | |
| Broken bones or fractures (describe) | | |
| Neck injury | | |
| Other (describe) | | |
| Other (describe) | | |
| Diagnostic Studies | When | Comments |
| Blood Tests | | |
| Bone Density Test | | |
| Carotid Artery Ultrasound | | |
| Colonoscopy | | |
| EKG | | |
| Liver Scan | | |
| Mammogram | | |
| Neck X-Ray (Please indicate type) | | |
| Other (describe) | | |
| Other (describe) | | |
| Surgeries | When | Comments |
| Appendectomy | | |
| Dental Surgery | | |
| Gall Bladder | | |
| Hernia | | |
| Hysterectomy | | |
| Tonsillectomy | | |
| Tubes In Ears | | |
| Other (describe) | | |
| Other (describe) | | |

HOSPITALIZATIONS

| Where | When | Reason |
|-------|------|--------|
| | | |
| | | |
| | | |
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| | | |

MEDICATIONS

| How often have you taken antibiotics | < 5 Times | > 5 Times | Comments |
|--------------------------------------|-----------|-----------|----------|
| Infancy/Childhood | | | |
| Teen | | | |
| Adult | | | |

| How often have you taken oral steroids? (e.g., Prednisone, Cortisone, etc.) | < 5 Times | > 5 Times | Comments |
|--|-----------|-----------|----------|
| Infancy/Childhood | | | |
| Teen | | | |
| Adult | | | |

**List all medications you are currently on. Include bio-identical hormones and over the counter.
Please use additional sheets of paper if necessary.**

| Type & Brand | Start Date | End Date | Dosage |
|--------------|------------|----------|--------|
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**List all vitamins, minerals, and any nutritional supplements that you are taking now.
Please use additional sheets of paper if necessary.**

| Type & Brand | Start Date | End Date | Dosage |
|--------------|------------|----------|--------|
| | | | |
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Are you allergic to any medication, vitamin, mineral, or other nutritional supplement?

Yes No

If yes, please list: _____

FAMILY HEALTH HISTORY

| Check all family members that apply: | Father | Mother | Brother(s) | Sister(s) | Children | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather |
|---|---------------|---------------|-------------------|------------------|-----------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| Age (If still living) | | | | | | | | | |
| Age at death (If deceased) | | | | | | | | | |
| Heart Attack | | | | | | | | | |

FAMILY HEALTH HISTORY

| Check all family member that apply: | Father | Mother | Brother(s) | Sister(s) | Children | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather |
|--|---------------|---------------|-------------------|------------------|-----------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| Stroke | | | | | | | | | |
| Uterine Cancer | | | | | | | | | |
| Colon Cancer | | | | | | | | | |
| Breast Cancer | | | | | | | | | |
| Ovarian Cancer | | | | | | | | | |
| Prostate Cancer | | | | | | | | | |
| Skin Cancer | | | | | | | | | |
| ADD/ADHD | | | | | | | | | |
| ALS or other Motor Neuron Disease | | | | | | | | | |
| Alzheimer's | | | | | | | | | |
| Anemia | | | | | | | | | |
| Anxiety | | | | | | | | | |
| Arthritis | | | | | | | | | |
| Autism | | | | | | | | | |
| Autoimmune Diseases | | | | | | | | | |
| Bipolar Disease | | | | | | | | | |
| Bladder Disease | | | | | | | | | |
| Blood Clotting Problems | | | | | | | | | |
| Celiac Disease | | | | | | | | | |
| Dementia | | | | | | | | | |
| Depression | | | | | | | | | |

FAMILY HEALTH HISTORY

Check all family member that apply:

| | Father | Mother | Brother(s) | Sister(s) | Children | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather |
|---|--------|--------|------------|-----------|----------|----------------------|----------------------|----------------------|----------------------|
| Diabetes | | | | | | | | | |
| Eczema | | | | | | | | | |
| Emphysema | | | | | | | | | |
| Environmental Sensitivities | | | | | | | | | |
| Epilepsy | | | | | | | | | |
| Flu | | | | | | | | | |
| Genetic Disorders | | | | | | | | | |
| Glaucoma | | | | | | | | | |
| Headache | | | | | | | | | |
| Heart Disease | | | | | | | | | |
| High Blood Pressure | | | | | | | | | |
| High Cholesterol | | | | | | | | | |
| Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing, Spondylitis) | | | | | | | | | |
| Inflammatory Bowel Disease | | | | | | | | | |
| Insomnia | | | | | | | | | |
| Irritable Bowel Disease | | | | | | | | | |
| Kidney Disease | | | | | | | | | |
| Multiple Sclerosis | | | | | | | | | |
| Nervous Breakdown | | | | | | | | | |
| Obesity | | | | | | | | | |

FAMILY HEALTH HISTORY

Check all family member that apply:

| | Father | Mother | Brother(s) | Sister(s) | Children | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather |
|-----------------------|--------|--------|------------|-----------|----------|----------------------|----------------------|----------------------|----------------------|
| Osteoporosis | | | | | | | | | |
| Parkinson's | | | | | | | | | |
| Pneumonia | | | | | | | | | |
| Psoriasis | | | | | | | | | |
| Psychiatric Disorders | | | | | | | | | |
| Schizophrenia | | | | | | | | | |
| Sleep Apnea | | | | | | | | | |
| Smoking Addiction | | | | | | | | | |
| Substance Abuse | | | | | | | | | |
| Ulcers | | | | | | | | | |

Please use the space below to list any other conditions not mentioned above.

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CHILDHOOD HISTORY

Please answer to the best of your knowledge.

| | Yes | No | Don't Know | Comment |
|--|-----|----|------------|---------|
| Were you a full-term baby? | | | | |
| A premature birth ('Preemie')? | | | | |
| Breast fed? | | | | |
| Bottle fed? | | | | |
| When pregnant with you, did your mother: | | | | |
| Smoke tobacco? | | | | |
| Use recreational drugs? | | | | |
| Drink alcohol? | | | | |
| Use estrogen? | | | | |
| Other prescription or non-prescription meds? | | | | |

| IMMUNIZATION HISTORY Please indicate if you have been vaccinated against any of the following diseases: | Yes | No | Don't Know | Comment |
|---|-----|----|------------|---------|
| Smallpox | | | | |
| Tetanus | | | | |
| Diphtheria | | | | |
| Pertussis | | | | |
| Polio (Oral) | | | | |
| Polio (Injection) | | | | |
| Mumps | | | | |
| Measles | | | | |
| Rubella (German Measles) | | | | |
| Typhoid | | | | |
| Cholera | | | | |
| Influenza | | | | |

CHILDHOOD HISTORY

Please answer to the best of your knowledge.

| CHILDHOOD DIET Was your childhood diet high in: | Yes | No | Don't Know | Comment |
|--|------------|-----------|-------------------|----------------|
| Sugar (Sweets, candy, cookies, etc.) | | | | |
| Soda | | | | |
| Fast food, pre-packaged foods, artificial sweeteners | | | | |
| Milk, cheeses, other dairy products | | | | |
| Meat, vegetables, and potato diet | | | | |
| Vegetarian diet | | | | |
| Diet high in white breads | | | | |

As a child, were there foods that you had to avoid because they gave you symptoms?

Yes No

If yes, please explain (Example: Milk = Diarrhea): _____

CHILDHOOD ILLNESS

Please indicate which of the following problems/conditions you experienced as a child and the approximate age of onset.

| | Yes | Age | Comment |
|-----------------------------------|-----|-----|---------|
| Asthma | | | |
| Chicken Pox | | | |
| Colic | | | |
| Congenital problems | | | |
| Ear infections | | | |
| Fever blisters | | | |
| Frequent colds or flu | | | |
| Frequent headaches | | | |
| Hyperactivity | | | |
| Jaundice | | | |
| Measles | | | |
| Mumps | | | |
| Pneumonia | | | |
| Seasonal allergies | | | |
| Skin disorders (e.g., dermatitis) | | | |
| Upset stomach, digestive problems | | | |
| Whooping cough | | | |
| Other (describe) | | | |

As a child, did you have a high absence from school?

Yes No

If yes, please explain: _____

As a child, did you experience chronic exposure to secondhand smoke in your home? Y / N

LIFESTYLE HISTORY

TOBACCO HISTORY

Have you ever used tobacco? Y / N

If yes, what type? Cigarette ___ Smokeless ___ Cigar ___ Pipe ___ Patch/Gum ___

How much? _____ Number of years? ___ If not a current user, year you quit? ___

Attempts to quit: ___

Are you exposed to 2nd hand smoke regularly? If yes, please explain: _____

ALCOHOL INTAKE

Have you ever used alcohol? Y / N

If yes, how often do you drink alcohol now? Please check one:

No longer drink alcohol

Average 1 - 3 drinks per week

Average 4 - 6 drinks per week

Average 7- 10 drinks per week

Average > 10 drinks per week

Do you notice a tolerance to alcohol? (Can you "hold" more than other?) Y / N

OTHER SUBSTANCES (NO judgement. Please answer honestly.)

Do you currently, or have you previously used recreational drugs? Y / N

If yes, please describe what type(s), method(s), and frequency: _____

To your knowledge, have you ever been exposed to toxic metals in your job or home? Y / N

If yes, please select all that apply:

Lead

Arsenic

Aluminum

Cadmium

Mercury

SLEEP AND REST HISTORY

Average number of hours that you sleep at night? < 6 ___ 6 - 8 ___ 8 - 10 ___ > 10 ___

Do you experience any of the following (select all that apply):

Have trouble falling asleep

Feel rested upon waking

Have problems with insomnia

Have trouble staying asleep

Snore

CPAP

Use a sleeping aid

Please describe: _____

NUTRITION HISTORY

Have you made any changes in your eating habits because of your health? Y / N

If yes, when did you make these changes?

How much of the following do you consume each week?

Candy _____

Cheese _____

Chocolate _____

Cups of coffee containing caffeine _____

Cups of decaffeinated coffee or tea _____

Cups of hot chocolate _____

Cups of tea containing caffeine _____

Ice Cream _____

Salty Foods _____

Slices of white bread (rolls, bagels, etc.) _____

Soda with caffeine _____

Soda without caffeine _____

Diet soda _____

Do you currently follow a special diet or nutritional program? Y / N

Ovo-lacto Vegetarian

Diabetic Vegan

Dairy restricted Blood type diet

Other: _____

NUTRITION HISTORY

Is there anything special about your diet that we should know? Y / N

If yes, please describe: _____

Do you have symptoms ***immediately after*** eating such as belching, bloating, sneezing, hives, etc.? Y / N

If yes, are these symptoms associated with any food or supplement? Y / N

If yes, please name the food or supplement and symptoms: _____

Do you have ***delayed*** symptoms after eating certain foods such as fatigue, muscle ache, sinus congestion, etc.?

Symptoms may not be evident for 24 hours or more. Y / N

If yes, please describe the food and symptoms: _____

Do you fee ***worse*** when you eat a lot of:

High fat foods Refined sugar (junk food)

High protein foods Fried foods

High carbohydrate foods 1 or 2 alcoholic drinks

Other Describe: _____

Do you fee ***better*** when you eat a lot of:

High fat foods Refined sugar (junk food)

High protein foods Fried foods

High carbohydrate foods 1 or 2 alcoholic drinks

Other Describe: _____

Does skipping meals greatly affect your symptoms? Y / N

Has there ever been a food that you have craved or “binged” on over a period of time? Y / N

If yes, please list what food(s): _____

NUTRITION HISTORY

Please check all that apply as it relates to your bowel movements:

FREQUENCY:

- More than 3x/day
- 1 - 3x/day
- 4 - 6x/week
- 2 - 3x/week
- 1 or fewer x/week

CONSISTENCY:

- Soft and well formed
- Often floats
- Difficult to pass
- Diarrhea
- Thick, long, or narrow

COLOR:

- Medium brown consistently
- Very dark or black
- Greenish
- Blood is visible
- Varies a lot
- Dark brown consistently
- Yellow, light brown
- Greasy, shiny

COMMENTS:

DENTAL HISTORY

Please check all that apply:

- Problems with sore gums (gingivitis)?
- Ringing in the ears (Tinnitus)?
- Have TMJ (Temporal Mandibular Joint) problems?
- Metallic taste in mouth?
- Problems with bad breath (Halitosis) or white tongue (thrush)?
- Previously or currently wear braces?
- Problems chewing?
- Floss regularly?
- Amalgam (silver) fillings? If yes, how many?
- Did you receive these fillings as a child?

DENTAL HISTORY

List your approximate age and the type of dental work done from childhood until present:

| Age | Type of dental work | Describe any health problems that followed dental work: |
|-----|---------------------|---|
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EXERCISE HISTORY

Do you exercise regularly? Y / N
If yes, please indicate:

| TYPE OF EXERCISE | Times/Week | | | | Length of session (Min.) | | | |
|------------------------------------|------------|--|--|--|--------------------------|--|--|--|
| | | | | | | | | |
| Jogging/walking | | | | | | | | |
| Aerobics | | | | | | | | |
| Strength training | | | | | | | | |
| Pilates/Yoga/Tai Chi | | | | | | | | |
| Sports (Tennis, golf, water, etc.) | | | | | | | | |
| Other: | | | | | | | | |

If you do not exercise regularly, please indicate what problems limit your activity (low motivation, fatigue after exercising, etc.): _____

SOCIAL HISTORY

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health. Informing your doctor allows him/her to offer you supportive treatment options and optimize the outcome of your health care.

STRESS/PSYCHOSOCIAL HISTORY

- Are you overall happy? Y / N
- Do you feel you can easily handle the stress in your life? Y / N
- If no, do you believe that stress is presently reducing the quality of your life? Y / N
- If yes, do you believe that you know the source of your stress? Y / N
- If yes, what do you believe it to be? _____
- Have you ever contemplated suicide? Y / N
- If yes, how often? _____
- When was the last time? _____
- Have you ever sought help through counseling? Y / N
- If yes, what type? (e.g., pastor, psychologist, etc.) _____
- Did it help? Y / N

| How satisfied are you with: | Perfect | Satisfied | Just OK | Dissatisfied | Terrible | Doesn't apply |
|-----------------------------|---------|-----------|---------|--------------|----------|---------------|
| School life | | | | | | |
| Your job | | | | | | |
| Your social life | | | | | | |
| Close friends | | | | | | |
| Quality of sex | | | | | | |
| Quantity of sex | | | | | | |
| Your significant other | | | | | | |
| Your children | | | | | | |
| Your parents | | | | | | |

Which of the following provide you emotional support? Circle all that apply:

Spouse Family Friends Religion/Spirituality Pets Other _____

SOCIAL HISTORY

Have you ever been involved in abusive relationships (physical and/or emotional)? Y / N

Have you ever been a victim of a crime, or experienced a significant trauma? Y / N

Is alcoholism or substance abuse present in your relationships now? Y / N

If yes, do you need resources to help you/your loved one? Y / N

How important is religion/spirituality for you and your family's life?

Not at all important ____ Somewhat important ____ Extremely important ____

Do you practice meditation or relaxation techniques? Y / N

If yes, how often? _____

Circle all that apply:

Yoga Meditation Imagery Breathing Tai Chi Prayer Other _____

What hobbies and leisure activities do you do for fun?

Is there anything that you would like to discuss with the doctor today that you feel was not covered? Y / N

If yes, please list your comments below:

FEMALE MEDICAL HISTORY

Age at onset of first period: _____ Approximate date of onset: _____

What are you using for contraception now? _____

Have you ever used oral, injected, patch, or ring hormone contraceptives, or used Emergency Contraception?

Y / N If yes, when? From _____ to _____

Do you suffer from any side effects?

Y / N Explain: _____

Are you now, or have you ever used an IUD? Y / N What type? (Paraguard, Mirena, etc.) _____

When? _____ For how long? _____

While under the use of any birth control method, did you experience the following? Check all that apply:

- | | | | |
|----------------------|--------------------------|------------------------|--------------------------|
| Yeast | <input type="checkbox"/> | Sweet cravings | <input type="checkbox"/> |
| Heavy/light bleeding | <input type="checkbox"/> | Fatigue | <input type="checkbox"/> |
| Mood | <input type="checkbox"/> | Depression | <input type="checkbox"/> |
| Weight gain | <input type="checkbox"/> | Palpitations | <input type="checkbox"/> |
| Acne | <input type="checkbox"/> | Other (describe) _____ | |

Please use the space below for any additional explanation:

Are you currently, or have you ever used fertility treatment?

Y / N Explain: _____

Do you have any history of abnormal Pap tests? _____

Y / N Explain: _____

Do you have any history of vaginal infections?

Y / N Explain: _____

Please describe any treatment and/or medication for this: _____

Do you have any history of the following conditions? Check all that apply:

- | | | | |
|-----------------------------|--------------------------|------------------------|--------------------------|
| Ovarian Cysts | <input type="checkbox"/> | Endometriosis | <input type="checkbox"/> |
| Fibrocystic Breasts | <input type="checkbox"/> | Lichen Sclerosis | <input type="checkbox"/> |
| Polycystic Ovarian Syndrome | <input type="checkbox"/> | Vulvodynia | <input type="checkbox"/> |
| Uterine Fibroids | <input type="checkbox"/> | Other (describe) _____ | |

FEMALE MEDICAL HISTORY

DIAGNOSTIC TESTING

Please list the most recent date and results for the following:

| | | | | |
|---------------------|-------------|------------|--------------|-------------------------|
| PAP | ___/___/___ | Normal ___ | Abnormal ___ | |
| Mammogram | ___/___/___ | Normal ___ | Abnormal ___ | |
| Breast biopsy | ___/___/___ | Normal ___ | Abnormal ___ | |
| Breast thermography | ___/___/___ | Normal ___ | Abnormal ___ | |
| Bone density | ___/___/___ | High ___ | Low ___ | Within Normal Range ___ |

PREGNANCY HISTORY (to be completed by all women, if applicable)

Have you ever been pregnant before? Y / N

Please list the age(s) of your children: _____

Number of pregnancies: _____

Number of live births: _____

Number of miscarriages: _____

How many weeks gestation at the time of miscarry: _____

Number of premature births: _____

Number of cesarean births: _____

Number of stillbirths: _____

Number of ectopic pregnancies: _____

Number of terminated pregnancies: _____

CYCLE HISTORY (to be completed by all women, if applicable)

What was the date of your last menstrual period? ___/___/___

Have you ever had tubal ligation surgery? Y / N Have you had an ablation? Y / N If yes, when? ___/___/___

If so, please list the date and specific details: _____

How many days is your current cycle (counting from the first day of bleeding to the first day of your next cycle)?

< 20 Days 20 - 30 Days 30 - 40 Days 40 - 50 Days > 50 Days

How many days does your menstruation typically last? _____

Would you describe your menstruation as: Easy Uncomfortable/Difficult Debilitating

FEMALE MEDICAL HISTORY

CYCLE HISTORY CONTINUED

What is/was your typical menstrual flow? Light Medium Heavy

When you are or were cycling, would you describe your cycles as regular? Y / N

If no, please give explanation: _____

If you have received any type of "treatment" for any cycle issues, please provide details below:

What type of product do you use during your cycle? Circle all that apply:

Pads Tampons Menstrual Cup Other _____

How many pads and/or tampons do you use on heavy days? _____

How often do you empty your cup? _____

During menstruation, do you pass blood clots? Y / N How often? _____

How would you describe your cramping? None Mild Moderate Severe

At what point in your cycle do you experience cramping? _____

Have you noticed any recent changes to your cycle? Y / N

If yes, please explain: _____

Do you experience any unusual or excessive vaginal discharge throughout the month? Y / N

If yes, when? _____

Do you experience itching or odor in the vaginal area? Y / N

If yes, when? _____

Do you experience any breast tenderness? None Mild Moderate Severe

If yes, at what point in your cycle? _____

Do you have nipple discharge at any point in your cycle? Y / N

If yes, when? _____

FEMALE MEDICAL HISTORY

MENOPAUSAL WOMEN

Menopause is reached after 1 full year without a menstrual cycle or after a hysterectomy.

Did you enter menopause naturally or due to a hysterectomy? _____

If hysterectomy, was it full or partial? _____

What age were you at the onset of menopause? _____ Year of onset? _____

Date of your last menstrual period? _____

Please describe any recent changes and/or symptoms associated with your cycle prior to menopause:

MALE MEDICAL HISTORY

When was your last prostate exam? ___/___/___

What were your most recent PSA results? _____ Date: _____

Does your bladder always feel full? YES NO SOMETIMES

Do you experience inconsistent pressure or pain during urination? YES NO SOMETIMES

Does ejaculation cause pain? YES NO SOMETIMES

Do you have premature ejaculation? YES NO SOMETIMES

Have you ever been diagnosed with low testosterone? YES NO SOMETIMES

Have you ever had testicular issues? (hydrocele, torsion, etc.) YES NO SOMETIMES

Have you experienced infertility? YES NO SOMETIMES

If yes, how was this diagnosed? _____

Please use the space below to describe any other symptoms you feel we should know about:

READINESS ASSESSMENT

In order to improve your health, please rate the following on a scale of 5 (very willing) to 1 (not willing):

| | | | | | |
|--|---|---|---|---|---|
| Significantly modify your diet | 5 | 4 | 3 | 2 | 1 |
| Take nutritional supplements each day | 5 | 4 | 3 | 2 | 1 |
| Keep a record of everything you eat each day | 5 | 4 | 3 | 2 | 1 |
| Modify your lifestyle (e.g., work demands, sleep habits, etc.) | 5 | 4 | 3 | 2 | 1 |
| Engage in regular exercise | 5 | 4 | 3 | 2 | 1 |
| Have periodic lab tests to assess progress | 5 | 4 | 3 | 2 | 1 |

Thank you for taking the time to complete this questionnaire.

This questionnaire is an adaptation of the Comprehensive Health History created by Wayne L. Sodano, D.C., D.A.B.C.I, and Ron Grisanti, D.C., D.A.B.C.O., M.S. at the Functional Medicine University, Sequoia Education Systems, Inc.

**PLEASE RETURN THESE FORMS ALONG WITH ANY MEDICAL RELEASES, YOUR 3 DAY FOOD DIARY,
AND YOUR CREDIT CARD AUTHORIZATION A MINIMUM OF 5 DAYS BEFORE YOUR SCHEDULED
APPOINTMENT.**

3 DAY DIET DIARY INSTRUCTIONS:

It is important to keep an accurate record of your USUAL food and beverage intake as a part of your treatment plan. Please complete your Diet Diary for **3 consecutive days, including one weekend day.**

While completing your diary, keep in mind the following:

- Do not change your eating behaviors yet, as the purpose of this food record is to analyze your present eating habits
- Record information as soon as possible after the food has been consumed
- Describe the food or beverage as accurately as possible e.g., milk - whole, 2%, nonfat; toast – whole wheat, white, buttered; chicken – fried, baked, breaded; coffee – decaffeinate with sugar and half & half, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages including water, coffee, tea, sports drinks, all sodas (diet & regular)
- Include any additional comments about your eating habits on this form. For example: craving sweets, skipped meals and why, when a meal was at a restaurant, etc.
- Please note all bowel movements and their consistency – regular, loose, firm, etc.

PLEASE COMPLETE AND SUBMIT THE FOLLOWING DIET DIARY (3pgs total) WITH THE REST OF YOUR INTAKE FORMS. DO NOT WAIT TO BRING WITH YOU TO YOUR APPOINTMENT.

3 DAY DIET DIARY:

DIET DIARY:

Name: _____

Date: _____

DAY 1

| TIME | FOOD/BEVERAGE/AMOUNT | COMMENTS |
|------|----------------------|----------|
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| | | |

Bowel movements – number, form, color, etc.,:

Stress/Mood/Emotions:

Other Comments:

3 DAY DIET DIARY:

DIET DIARY:

Name: _____

Date: _____

DAY 2

| TIME | FOOD/BEVERAGE/AMOUNT | COMMENTS |
|------|----------------------|----------|
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| | | |

Bowel movements – number, form, color, etc.,:

Stress/Mood/Emotions:

Other Comments:

3 DAY DIET DIARY:

DIET DIARY:

Name: _____

Date: _____

DAY 3

| TIME | FOOD/BEVERAGE/AMOUNT | COMMENTS |
|------|----------------------|----------|
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Bowel movements – number, form, color, etc.,:

Stress/Mood/Emotions:

Other Comments:
